Employee Change of Personal Information Form

ABC BOARD

INSTRUCTIONS: For changes to your personal information, complete the sections below that apply. All completed forms must be returned to the ABC Personnel Office at Alabama ABC Board, Personnel Office, 2715 Gunter Park Drive, West, Montgomery, AL 36109. The completed forms may be scanned and emailed to *felicia.mosley@abc.alabama.gov*, or faxed to: 334-260-5450. Copies of this form must be submitted to others according to division policies and procedures.

Name Information: You must also submit some form of official documentation such as marriage certificate, driver license, or other legal documents, etc.

Current Name: _____ Change to: _____

Use this section to provide any changes to your home address. You must also submit a State Employee's Membership Status Change form for insurance purposes and an Address Change Notification form for retirement purposes.

Current Home Address: _____ Change to: _____

_____ _____

Use this section to provide any changes to your home telephone number.

Current Home Phone: _____ Change to: _____

Work Information.

SSN: _____ Classification: _____ Employment Date: _____

Division: _____ District: _____ Store: _____

Use this section to provide any changes to your office address.

Current Office Address: _____ Change to: _____

_____ _____

Use this section to provide any changes to your emergency contact information.

Name: _____ Relationship: _____

Telephone Number: _____

Name: _____ Relationship: _____

Telephone Number: _____

Use this section to provide any changes to where your payroll check is to be mailed. Checks for store employees will be mailed to the store ONLY.

Name: _____

Address: _____

_____

Use this section to provide any changes to where your per diem check is to be mailed.

Name: _____

Address: _____

_____

Use this section to provide any comments or special instructions.

Employee's Signature: _____ Date: _____

IB03 10/13

STATE EMPLOYEE'S MEMBERSHIP STATUS CHANGE

SUBSCRIBER INFO Name (First, Middle Initial, Last)	CONTRACT NUMBER:	EFFECTIVE DATE OF CHANGE: Month/Day/Year

☐ Cancel Subscriber's coverage (part-time employees only) Date became part-time: _____

Check all plans this change applies to: ____ SEHIP ____ Supplemental ____ Optional ____ HRA

____ BCBS Dental ___ Southland Dental ___ Southland Vision

DROP DEPENDENT COVERAGE **Please check appropriate box.**	****ADDITIONS – PROVIDE DOCUMENTATION**** **Please check appropriate box.**
☐ Change from Family to Single Coverage	☐ Change from Single to Family Coverage – Add Dependent(s)
☐ Cancel dependents listed below from Family Coverage	☐ Add dependent(s) listed below to Family Coverage
Reason for Cancellation:	☐ Adding Former State Employee
☐ Death (give date):	Former Employee's Social Security #
☐ Divorce (copy of final divorce decree required)	Last work day:
☐ Other (explain/give date)	

First Name Middle Initial Last Name	Documentation is required. Relationship to Employee		Date of Birth	Social Security Number
	☐ Husband**	☐ Wife**		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

IMPORTANT If you are currently receiving a non-tobacco user premium discount, the discount will be discontinued when you add a spouse to coverage unless a new non-tobacco user discount application is submitted to the SEIB.

** When adding a spouse to SEHIP coverage, a spousal surcharge of $50 per month will be applied. To receive a discount you must submit a Spousal Surcharge Waiver Application (IB25). Forms are available at www.alseib.org

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity, or representative acting on the State's behalf.

_____ _____
Employee Signature Date

State Agency:_____

☐ Change Address To:

_____
Street Address Apartment #

_____
City County State ZIP

Work Telephone_____

Home Telephone_____

E-Mail Address _____

State Employees' Health Insurance Plan

Eligible Dependent

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.):

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter,
   b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
   c. your stepchild,
   d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.

3. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent on you for 50% or more support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group health insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the SEIB within 60 days from the date the child would cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who meets the eligibility requirements except for age:

1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or
2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   a. the employee's spouse loses the other coverage because:
      - spouse's employer ceases operations, or
      - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
      - spouse's employer stopped contribution to coverage,
   b. a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
   c. Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The SEIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

In the event of the death of an active employee, who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payment to the SEIB. The SEIB must be notified within 90 days of the death.

Exclusion: You may not cover your wife, husband, or other dependents if they are independently covered as a State employee.

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8341 / 1-866-836-9737 / FAX: 334-517-9728

RSA ADDCHGF
07/11

ADDRESS CHANGE NOTIFICATION

Retirement Systems of Alabama
P. O. Box 302150 ♦ Montgomery, AL 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

- **Retired Members:** This form is for HOME ADDRESS ONLY and is NOT to be used for DIRECT DEPOSIT Bank addresses.
- This will change your Home Address with **ALL** RSA accounts and any distribution payments that are mailed to your home address.
- You can also change your address online through Member Online Services at https://mso.rsa-al.gov/.
- **For expedited address change, fax to 877.517.0021.**

PART I MEMBER INFORMATION

☐ Employees' Retirement System ☐ Teachers' Retirement System ☐ Judicial Retirement Fund

☐ Non-RSA members who only have a RSA-1 account

Name _____
First Middle Last Maiden

Date of Birth _____ **Email Address** _____
Month Day Year

Social Security Number _____ **OR** **PID Number** _____

PART II ADDRESS INFORMATION

Effective Date of New Address _____
Month Day Year

Old Address

Address _____
Street Address or P. O. Box City State Zip Code

New Address

Address _____
Street Address or P. O. Box City State Zip Code

Member Signature _____ **Date** _____

You must print, sign, and mail or fax this completed form to the RSA.